State of California Department of Consumer Affairs

**BOARD OF REGISTERED NURSING**
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TDD (916) 322-1700
Telephone (916) 322-3350
www.rn.ca.gov

# APPLICATION FOR CALIFORNIA PUBLIC HEALTH NURSE CERTIFICATE $75.00

**PLEASE PRINT OR TYPE**

| NAME: Last | First | Middle | Previous Names (Including Maiden): |
|---|---|---|---|
| | | | |

| ADDRESS: Street | City | State | Zip Code |
|---|---|---|---|
| | | | |

| SOCIAL SECURITY NUMBER: | DATE OF BIRTH: Month Day Year | TELEPHONE NUMBER: Home: ( ) Work: ( ) |
|---|---|---|
| | | |

| CALIFORNIA RN LICENSE NUMBER: (No Interim Permit) | EXPIRATION DATE: | (Office Use Only) CALIFORNIA PHN NUMBER: | EFFECTIVE DATE: |
|---|---|---|---|
| | | | |

## EDUCATION

| Education | NAME AND ADDRESS OF SCHOOL | Graduated Month/Yr | Degree Received |
|---|---|---|---|
| Baccalaureate ☐ | | | |
| | | | |
| Masters ☐ | | | |
| | | | |
| Public Health Nursing Education: | | | |
| | | | |
| | | | |
| | | | |
| Other, Specify: | | | |
| | | | |
| | | | |

## VERIFICATION OF CHILD ABUSE/NEGLECT PREVENTION TRAINING

| CE Provider/School Name | Course Name and Number | Number of Hours |
|---|---|---|
| | | |
| | | |
| | | |

**NOTE: TRANSCRIPTS MUST BE SUBMITTED FOR ALL APPLICANTS EXCEPT FOR THOSE WHO HAVE COMPLETED A CALIFORNIA APPROVED BSN PRE-LICENSURE PROGRAM.**

I certify under penalty of perjury under the laws of the State of California that all information provided in connection with this application for certification is true, correct, and complete. Providing false information or omitting required information is grounds for denial.

Signature of Applicant: _____ Date: _____